

IV. Feasibility of Including Hospital and University-Based Physicians in the Hospital Rate Setting System

Prepared by: Health Services Cost Review Commission

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Medicare Program – Background

On July 1, 1966, Medicare, authorized by Title XVIII of the Social Security Act, offered health insurance to almost all Americans age 65 or older. Coverage consisted of hospital insurance (Part A) and supplemental medical insurance (Part B), and benefits mirrored those then available from Blue Cross and Blue Shield plans.

Initially, Part A covered inpatient hospital care, skilled nursing facility (SNF) services, and home health care (hospice care was added in 1983). For inpatient care, hospitals were required to accept as payment in full Medicare's determination of the reasonable costs of treating the patient. Part B covered a wide range of non-institutional services and supplies including physician, outpatient hospital, laboratory, x-ray, therapy, medical equipment used in the home, and home health care not covered under Part A. In 1983, the Congress enacted a prospective payment system (PPS) for inpatient hospital services (Part A) that pays a predetermined amount for each discharge, from which Maryland is waived.

The payment method for physician services has also changed substantially since Medicare began. The most recent change in the physician payment method was the establishment of a resource based relative value scale (RBRVS) fee schedule in 1992. RBRVS sets rates for each procedure based on the physician work and other resources needed to deliver it. RBRVS was coupled with a volume performance standard under which annual increases in fee schedule amounts were decreased if total physician payments in previous years exceeded a pre-established growth rate for those years. Separate standards were set for evaluation and management services, surgeries, and other services. The Balanced Budget Act of 1997 (BBA) made some adjustments to RBRVS method including setting one growth measure for all physician services to replace the three performance standards.¹ Unlike inpatient hospital services, Maryland is not waived from RBRVS or other Part B physician requirements.

Hospital and University Based Physicians

It is not uncommon for hospital and university-based physicians (“hospital based physicians”) to perform both administrative and patient care functions. Examples of administrative functions include: teaching, departmental oversight, budgeting, and research. The costs associated with the administrative functions are covered under Part A of the Medicare Program (known as provider component costs), while the costs associated with patient care are covered under Part B (known as professional component costs).

¹ National Bipartisan Commission on the Future of Medicare, “Medicare - From Start to Today.”, Washington, DC June 1998.

Hospital-based physicians are typically compensated for their efforts by either the hospital or university system for which they work or through billings they make to insurers and/or patients. When Medicare began in 1966, hospital-based physicians were typically contractual employees of the hospital, with their duties specified in the contract and with incomes set at a fixed monthly sum or as a percentage of revenues. Hospitals compensating physicians for both Part A and Part B services were, for several years, reimbursed by Medicare through a process known as combined billing. Under this process, hospitals billed a single or combined charge for both the provider and professional components under Part A of the Program, even though the responsibility of the charge was shared by Parts A and B. A settlement between Parts A and B was made at the end of the hospital's fiscal year. Today, Medicare no longer permits bundling of physician and facility costs for reimbursement and requires that provider and professional costs be billed distinctly.

Medicare has, in the past, approved waivers from its federal payment policies with regard to physicians on a very limited, short-term basis. The most recent example of this occurred from 1991-1996, where Medicare agreed to pay a single rate for both inpatient hospital and physician services for two Diagnosis Related Groups (DRGs) related to heart bypass surgery to seven hospitals that chose to participate in the demonstration project. The hospital and physicians were free to divide up the single payment any way they chose, and physicians were not permitted to balance bill patients. According to the Health Care Financing Administration's (now CMS) report following the project², the "most salient accomplishment of the demonstration was the reduction in hospital costs," where physicians were able to change their practice patterns and shorten length of stay, substitute generic drugs for brand drugs, and reduce unnecessary testing and other services. Aligning physician and hospital incentives with a single payment was "key to the change." The fact that consulting physicians could not bill Medicare directly, however, "proved contentious in several sites, especially in academic medical centers where fee-for-service consultations were more common. Surgeons also cut back on their use of consultants, which aggravated them even more."³ In some sites, specialists argued that quality of care was being compromised, though they did not provide evidence of poorer quality when requested. Of benefit to the physicians, however, was the willingness of each hospital to take responsibility for collecting any deductible and coinsurance amounts on both Part A and Part B. In general, physicians were paid promptly by the hospital upon discharge or within two weeks. Delays of several months in collecting the coinsurance from supplemental insurers resulted in "significant cash flow problems for hospitals instead of physicians." Under this demonstration project, bundling Part A and Part B payments appears to have had very mixed results for both hospitals and physicians.

² Centers for Medicare and Medicaid, "Medicare Participating Heart Bypass Center Demonstration." Extramural Research Report, Baltimore, MD. September 1998.

³ Ibid, Page 21.

HSCRC's Past Experience in Establishing Physician Rates

The HSCRC started setting hospital rates in 1974. At that time, the HSCRC-approved rates applied only to commercial insurers and HMOs. In 1977, the Commission negotiated a waiver from Medicare hospital payment rules to bring federal Medicare payments under Maryland control. Medicare reimburses Maryland hospitals according to rates established by the HSCRC as long as the State continues to meet a two-part test. The two-part waiver test allows Medicare to participate in the Maryland system as long as the two following conditions are met:

- a. all other payers participating in the system pay HSCRC-set rates; and
- b. the rate of growth in Medicare payments to Maryland hospitals from 1981 to the present is not greater than the rate of growth in Medicare payments to hospitals nationally over the same time period (1981 - present).

With this waiver, the Maryland system became “all-payer.” What is meant by “all-payer” is that the rates established by the Commission must be charged to all patients regardless of their insurance status (Medicare, Medicaid, Blue Cross, HMO, etc.) and all payers must reimburse hospitals based on these rates.

At the time that the HSCRC assumed regulatory control of hospital rates, if a hospital- based physician was compensated by a hospital, the HSCRC reviewed the compensation for reasonableness using the same criteria used for other reported hospital costs. Under these circumstances, the HSCRC exercised control over a physician’s provider and professional related income.

In an effort to avoid a two-tiered system of rate regulation for physician services, the HSCRC also sought to regulate the rates of direct billing hospital based physicians who were not compensated by the hospital. In 1977, after the Commission had issued a final order outlining this process, Holy Cross Hospital challenged the HSCRC’s authority to regulate these rates in Circuit Court. The challenge was based on the contention that, while the HSCRC has the authority over the “total services of the hospital,” services of direct billers are not part of the “total services.” In 1979, after a lengthy legal debate, Holy Cross Hospital prevailed.⁴ In a later case *HSCRC v. Harford Memorial Hospital*, 296 Md. 17(1983), the Court of Appeals ruled that the Commission had the authority under the statute in effect in 1983 to include in hospital rates the cost of physician services when the hospital controlled the billing.

In *Holy Cross*, the physicians controlled the billing, and their fees were determined to be outside HSCRC jurisdiction. In *Harford Memorial*, the hospital controlled the billing and, therefore, the amount paid to its radiologists fell within Commission rate setting. This ruling placed the Commission in the untenable position of being forced to set rates only for those physicians who wanted them (presumably in order to extract higher payments from third party payers than the market would otherwise permit) and not for those who preferred otherwise (presumably those for whom the HSCRC would set lower rates than the market would otherwise provide).

⁴ *Holy Cross Hospital v. HSCRC* 283 Md 677, 393 A.2d 181 (1978); 290 Md. 508, 431 A.2d 641 (1981).

Based on the recommendations from the Governor's Task Force on Health Care Cost Containment and discussions with the Medicare program, Chapter 112 of the Laws of 1985 was enacted, which removed costs associated with physician treatment of individual inpatients or outpatients, otherwise known as "identified physician costs," from the HSCRC's rate setting authority. Prior to this change, the term "identified physician costs" was defined in Commission regulation as those costs incurred by a hospital resulting from "professional medical services which are personally rendered for an individual patient or outpatient by a physician and which contribute to the diagnosis or treatment of the individual patient." Under the Maryland Code, Health General §19-201 currently, the definition of "hospital services" - i.e., those services the Commission has the authority to regulate - does not include physician services unless the costs associated with those services were included in rates on June 30, 1985 and were not subsequently removed from rates. As of December 2003, three hospitals still had Part B rates included in their hospital rate, totaling \$599,374.⁵ These amounts remain in rates by agreement with Medicare until the hospital petitions the HSCRC to have them removed; upon removal, Medicare will not approve their re-inclusion, since Medicare no longer permits combined Part A and Part B billing.

Aside from this unique circumstance where Medicare has permitted certain preexisting physician costs into current hospital rates, Maryland's hospital rate setting system is governed by the Medicare waivers set forth in the Social Security Act (SSA). Section 1814(b) of the SSA provides for Medicare payment of HSCRC-set rates at Maryland hospitals subject to the two-part test described earlier. Because this waiver appears under the Part A Section of the SSA, the waiver applies only to inpatient hospital services as defined under Section 1816(b). Section 1816(b) explicitly prohibits payment under Part A for physician services except for the reasonable costs of residents and interns and physician costs in hospitals wherein all physicians have agreed to forego Part B billing for Medicare services. Maryland hospital rates currently contain a component for teaching and graduate medical education costs.

Section 1833(a)(2) of the SSA provides for Medicare payment of HSCRC-set rates for outpatient facility charges provided at Maryland hospitals as long as the conditions of the two-part test are met. Section 1833(a)(2) applies only to institutional providers as defined in Section 1823(a)(2) and not to physicians, which are referenced in Section 1832(a)(1). Section 1832(a)(2) does allow the same physician, resident, and intern costs as enumerated in Section 1861(b), as described under "Part A" above. Again, while Maryland is excluded from Medicare payment policies in several instance, these waivers do not apply to Medicare's Part B physician reimbursement policies.

Desirability and Feasibility of Obtaining Waiver to Cover Part B Physician Services

As mentioned in earlier sections of this report, practitioner fees paid by Maryland private insurers were essentially unchanged from 1999 to 2001, and appear to have declined slightly, on

⁵ Hospitals are: Civista, Holy Cross, and Chester River Hospital Center.

average, from 2000 to 2001.⁶ Nationwide, the average of private payers' fees fell slightly between 1994 and 2001. Research conducted on behalf of the Medicare Payment Advisory Commission (MedPAC) to assess the difference between Medicare and private rates found that nationally Medicare's rates were about 77 to 79 percent of private rates in 2002.⁷ Private plans also reported that Medicare reductions in payment rates have increased pressure on them to raise their rates.⁸ According to the most recent MHCC research, private payment rates are about 102 percent of Medicare payment rates in Maryland.⁹ Future MHCC research will focus on why private payer rates are lower in Maryland

Against this backdrop of restraint on physician fees, the adequacy of physician reimbursement has been hotly contested in the Maryland legislature over the past several years. Discussion has focused on establishing minimum reimbursement levels for specific groups of physicians who are obligated to provide care to all patients, including physicians working in emergency rooms and trauma centers. These physicians must accept patients regardless of insurance status (for insured patients, please see discussion under Balance Billing section). Additionally, legislation from the 2002 Legislative Session requires the Department of Health and Mental Hygiene to annually set the fee-for-service reimbursement rates for the Maryland Children's Health Program (MCHP) and the Medicaid program in a manner that ensures provider participation.

A component of provider participation, and a frequent complaint of physicians, however, continues to be the level of uncompensated care provided by physicians and insufficient physician reimbursement. Uninsured patients are rarely, if ever, able to pay their medical expenses following treatment, which means that the treating physician receives no reimbursement for a percentage of the services he or she provides. Further, physicians indicate that even when patients are insured, reimbursement levels, especially from public payers, do not cover the cost of providing care. Reimbursement rates from commercial insurers, which have historically been sufficient enough to cover the cost of care as well as to subsidize the losses from other payers and the uninsured, have declined or remained stable in recent years.

Maryland's hospital all payer rate setting system permits hospitals to equitably recoup the reasonable cost of delivering care to the uninsured. Due to the state's Medicare waiver, however, coverage of physician services is not currently possible, as discussed earlier. The most equitable system of financing social costs such as uncompensated care is best accomplished in a broad-based, equitable manner; therefore, it may be desirable for policymakers to consider establishing a rate setting system for physicians, along with a variety of other health care services, similar to Maryland's hospital rate setting system. Many conditions would need to be met, however, before the establishment of a regulatory system for physician charges could be implemented.

A decision on whether or not to intervene and regulate health care services and reimbursement should be based on the existence (or lack thereof) of certain problems or failures in the health

6 Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, (Washington, DC: MedPAC, March 2003) p 76.

7 This would mean that nationally private payers reimburse on average about 126-129 percent of Medicare rates.

8 Ibid, p 76.

9 MHCC, Adequacy of Payment to Costs, (Baltimore, MD, December, 2003)

care marketplace. Examples of such problems in the market for hospital services in the 1960s and 1970s in Maryland that triggered implementation of the rate setting system were: 1) uncontrollable increases in hospital costs; 2) inequities in reimbursement, i.e., different payment rates by different payers for the same services; 3) lack of access to care for those without health care insurance and an inability to equitably finance uncompensated care; and 4) inadequate payment and financial instability/insolvency for providers. The causes of these health care policy problems, or market failures, also relate directly to the dynamics of the national market for hospital services. An absence of accurate and timely information on the cost and outcomes of care or a system of fragmented and conflicting incentives contribute to and exacerbate the market disruptions mentioned earlier. ***Thus, any decision to apply rate regulation for physician services would first need to examine whether these or other problems exist in the market for physician services and then determine whether the presence of rate regulation could correct for the problematic market dynamics.*** Effective rate regulation relies heavily on the collection of audited, detailed, and timely financial and patient acuity data from the regulated entity to determine standards of reasonableness for rate setting. Experience has shown that, in Maryland, all physicians would need to be covered under such a regulatory structure. In the past, the physician community had been reluctant to provide such data and to participate in a statewide system.

Assuming that policymakers determined that all payers should participate, work would need to begin regarding the negotiation of Medicare and Medicaid waivers, taking care not to alter Maryland's existing Medicare waiver. This discussion would need to take place with the federal government, which has not approved a similar, comprehensive waiver in over twenty years. Finally, upon establishment of such a system, detailed financial data would be collected to establish base rates for physician services, which would presumably, be updated annually similar to Medicare. ***It bears repeating that regulation should not be seen as establishing a minimum (or "floor") payment for an industry– rather, it establishes a ceiling payment for services based on reasonable reported costs. Given these many contradicting circumstances, it is not feasible to establish a rate setting system for physicians in the near future for Maryland physicians.***